Psychiatric & Behavioral Emergencies

CBT 933

Part One *Recertification*

Part Two *Mastery*

Part One *Recertification*

Foreword

Each year EMT/FRs respond to, and are responsible for, a significant number of patients who have suffered from Psychiatric & Behavioral Emergencies. For a variety of reasons, including the growing incidence of violence, increased appreciation of the role of organic disease in altered mental status, widespread chemical dependence and substance abuse, the number of psychiatric presentations is on the rise. Thus, the practice of emergency psychiatry has changed dramatically over the past decade. New patterns of assessment and clinical care, the increase of data relevant to treatment and changes in the relation of mental health treatment to the healthcare field in general, translate into a unique set of challenges for the EMT/FR confronted with psychiatric emergencies in the field.

The difficulty of assessing individuals presenting with psychiatric complaints is compounded by stigmas associated with a psychiatric population, the perceived ambiguity of psychiatric diagnoses and the danger and/or risk presented to the EMT/FR. This module is designed to provide the basic knowledge to understand the most fundamental elements of emergent psychiatric presentations, assess and maintain safety of both the patient and healthcare workers in the field, and guide in the collection of data that will most efficiently and effectively facilitate transfer of the patient to an acute care setting and provide the receiving facility with relevant information.

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Goals

1. Early recognition
2. Meaningful intervention
3. Safe, rapid transport to the appropriate medical facility

Objectives

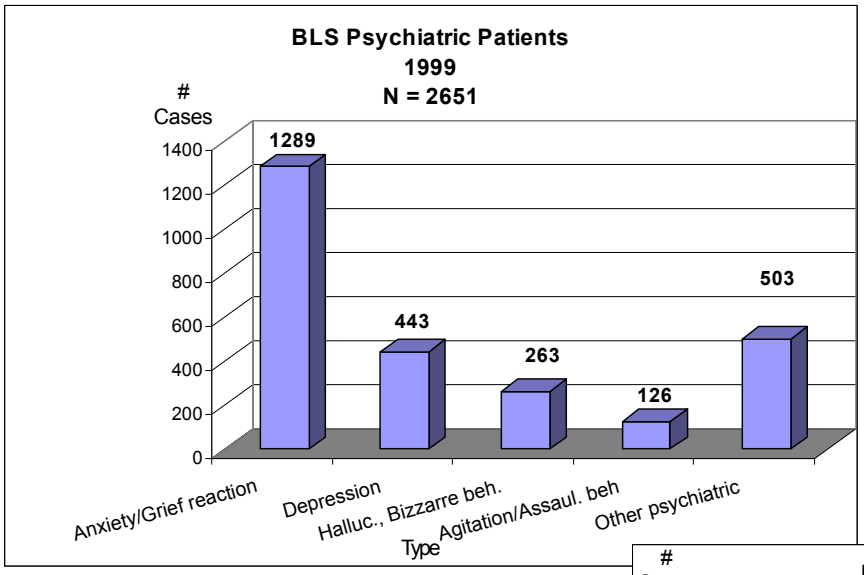
Performance Based

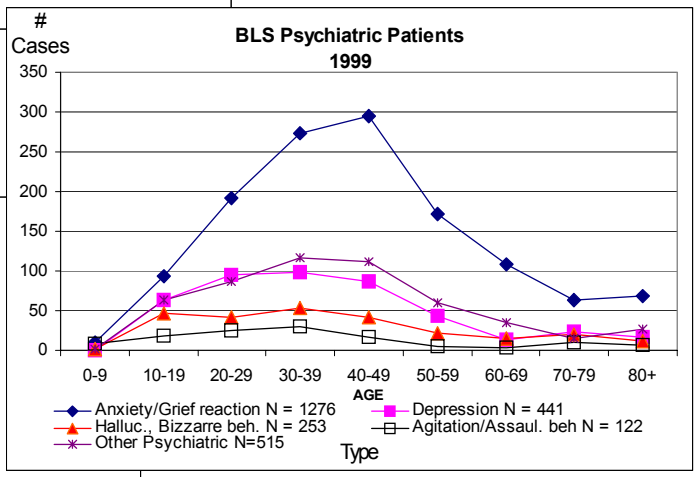
Given a partner, relevant equipment, and a patient with a psychiatric emergency, the EMT/FR will demonstrate treatment as specifically identified in the King County Emergency Medical Services BLS Patient Care Guidelines.

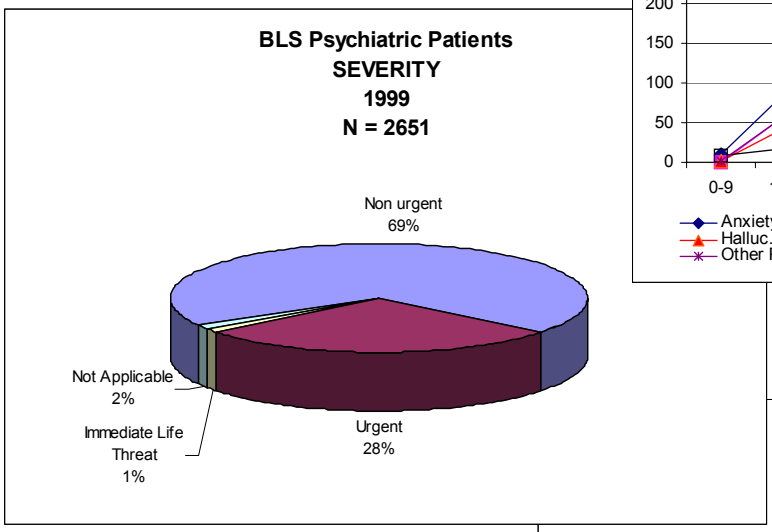
Cognitive Based

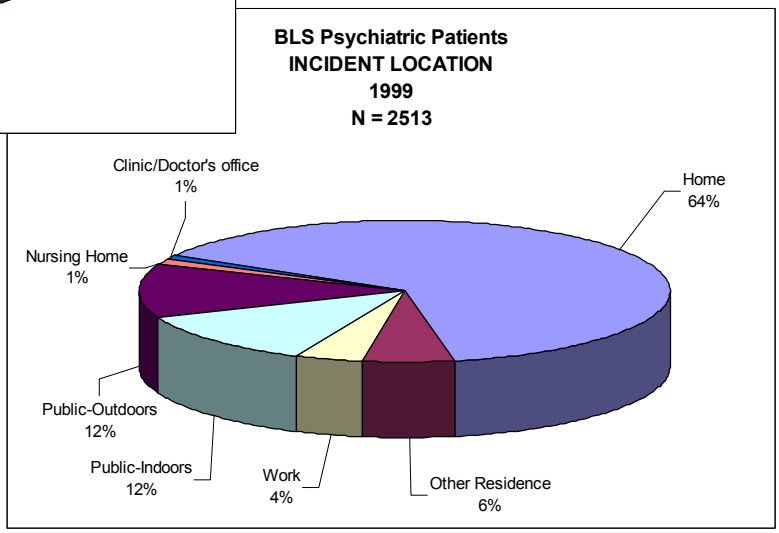
After studying the Competency Based Training (CBT) 521 Psychiatric Emergencies module, the EMT will verify cognitive learning by successfully passing a ten question written test by achieving a minimum score of 70%.

MIRF Facts

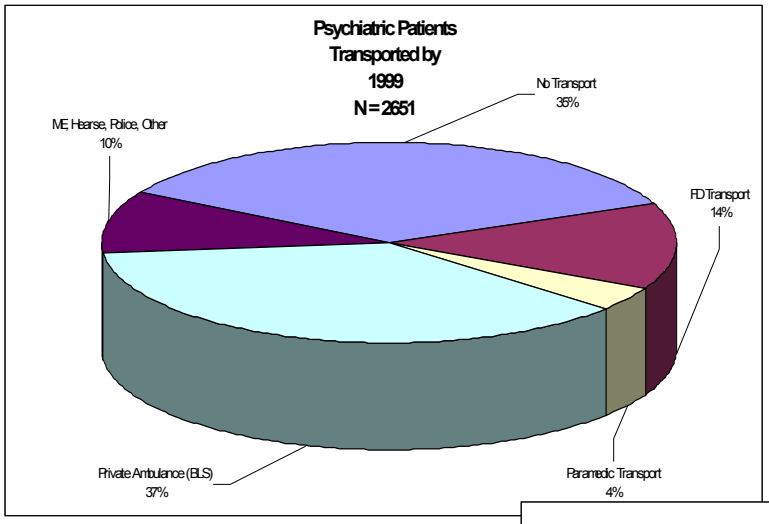

BLS Psychiatric Patients
1999
N = 2651
# Cases
1400
1200
1000
800
600
400
200
0
1289
443
263
126
503
Anxiety/Grief reaction
Depression
Halluc., Bizzarre beh.
Agitation/Assaul. beh
Other psychiatric
Type

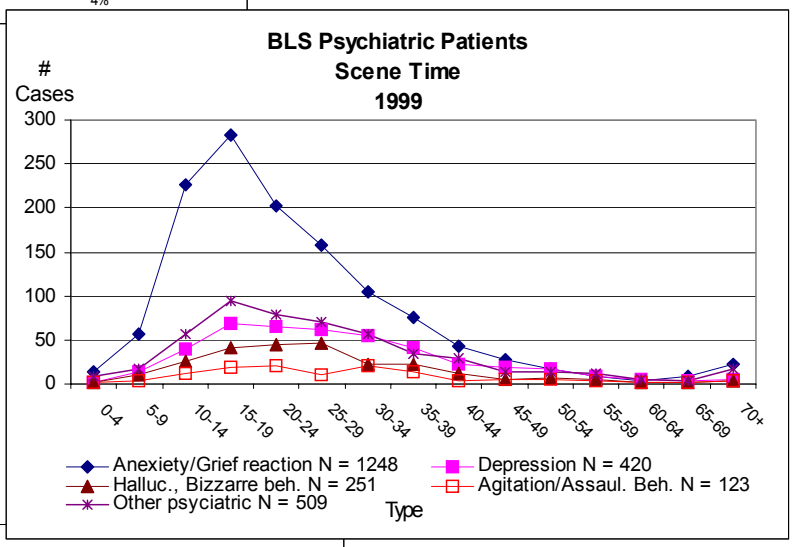

Cases
BLS Psychiatric Patients
1999
350
300
250
200
150
100
50
0
0-9
10-19
20-29
30-39
40-49
50-59
60-69
70-79
80+
AGE
Anxiety/Grief reaction N = 1276
Depression N = 441
Halluc., Bizzarre beh. N = 253
Agitation/Assaul. beh N = 122
Other Psychiatric N=515
Type

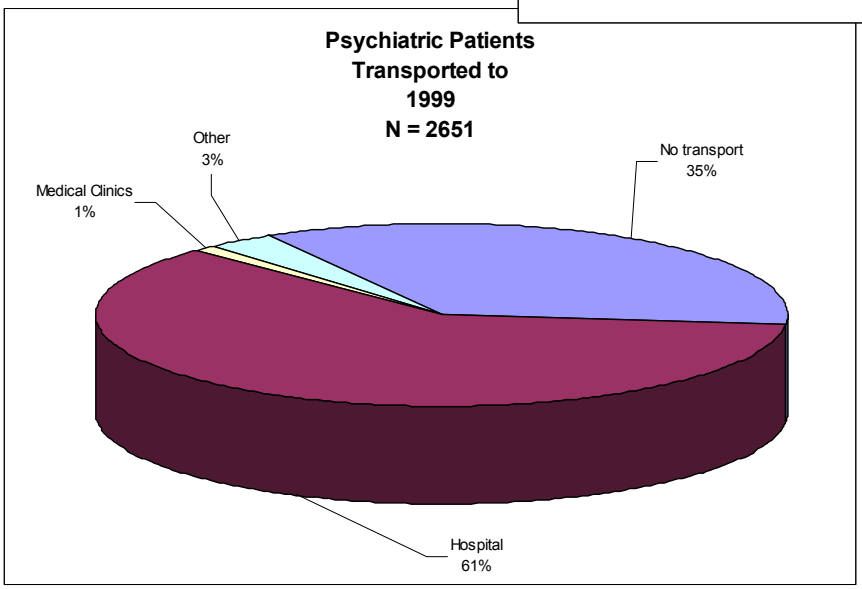

BLS Psychiatric Patients
SEVERITY
1999
N = 2651
Non urgent
69%
Not Applicable
2%
Immediate Life
Threat
1%
Urgent
28%


BLS Psychiatric Patients
INCIDENT LOCATION
1999
N = 2513
Clinic/Doctor's office
1%
Home
64%
Nursing Home
1%
Public-Outdoors
12%
Public-Indoors
12%
Work
4%
Other Residence
6%

MIRF Facts


Psychiatric Patients
Transported by
1999
N=2651
No Transport
35%
FD Transport
14%
Paramedic Transport
4%
Private Ambulance (BLS)
37%
ME, Hearse, Police, Other
10%


BLS Psychiatric Patients
Scene Time
1999
Cases
300
250
200
150
100
50
0
0-4
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70+
Anexiety/Grief reaction N = 1248
Depression N = 420
Halluc., Bizzarre beh. N = 251
Agitation/Assaul. Beh. N = 123
Other psyciatric N = 509
Type


Psychiatric Patients
Transported to
1999
N = 2651
Other
3%
No transport
35%
Medical Clinics
1%
Hospital
61%

Medical Terminology

Anxiety Disorders A group of psychiatric disorders characterized by subjective feelings of: anxiety, tension worry, apprehension, cognitive difficulties, behavioral restlessness, combined with physiologic signs (such as tremor, heart-pounding, hyper-vigilance, dilated pupils, agitation, sweat, shortness of breath) which, when mag nitude and or duration of symptoms exceed normal limits given preceding circumstances, becomes pathological.

Some of the more common anxiety disorders are:

Generalized: Undue or persistent worry for at least six months in relation to at least two or more life circumstances.
Panic: Attacks involving intense fear and apprehension, lasting several minutes, often accompanied by agoraphobia (fear of not being able to escape).
Acute stress: Acute reaction to extreme stress which occurs within four weeks of the stressor and lasts from two days to four weeks. It is often a predictor of PTSD
Post Traumatic Stress Disorder (PTSD): A reaction to an exception ally severe and unusual loss or stress, which induces clinical symptoms such as emotional blunting, intrusive ideas of the event and acute episodes of anxiety and depression.

Catatonia Extreme psychomotor retardation or agitation.

Clouding of Consciousness Incomplete or distorted awareness of the environment despite being fully awake.

Compulsions Thinking Repeated, stereotyped, overtly senseless actions or rituals, which are performed to prevent anxiety.

Concrete The inability to think abstractly, metaphorically, or hypothetically. Ideas and words are often limited to a single meaning and figures of speech are taken literally.

Confabulation The invention of responses, facts and events by a patient to mask an organic impairment.

Conversion Disorder — A change or loss in physical functioning that cannot be related to a physical condition and over which and individual does not have voluntary control of the symptoms.

Delirium — A change in mental status with abrupt onset of symptoms that are generally of short duration, including clouded sensorium, decreased level of consciousness, and the inability to focus, think logically and maintain attention. Delirium is a medical emergency with various possible etiologies including illicit substance abuse, head injury, sepsis, and others.

Delusion — A fixed, false conviction deduced from incorrect inferences about external reality, which are maintained despite obvious proof to the contrary.

Dementia — Intellectual deterioration from various etiologies (including Alzheimer's Disease) that is severe enough to impair an individual in daily function ing. The slow onset is characterized by progressive disorientation, shortened attention span and loss of cognitive function. To make clinical diagnosis various psychometric and other mental status testing as well as ADL testing and radiological testing are implemented to evaluate memory disturbances, language, perception, and decreased ability to learn and problem solve.

Dissociative Disorders

Amnesia Partial or total inability to recall past experiences for either organic or emotional reasons.

Dissociative Identity Disorder Previously called 'multiple personality disorder,' this condition is poorly understood and considered rare.

Depersonalization Disorder A condition characterized by periods in which patient has a strong and unpleasant sense of their own unreality, resulting in feelings of being separate from thoughts, emotions and self-identity and being mechanical in motion.

Developmental Disorder — Qualitative impairment in verbal and nonverbal skills, imaginative activity, intellectual skills and social/reciprocal interaction.

Echolalia — The meaningless, persistent, verbal repetition of words or sounds heard by the patient in response to the same stimulus, often said with a mocking tone.

ECT (Electro-convulsive Therapy)	The use of electricity via electrodes to produce a seizure, which changes neurotransmitter functions.
Flight of Ideas	Rapid changes in subject, delivered with accelerated speech that derive from understandable associations, distracting stimuli or play on words.
Grandiosity	An exaggerated feeling of one's importance, power, knowledge or iden tity, the degree of which can range from mild exaggeration of a true characteristic to psychotic delusions of grandeur.
Hallucination	A false perception in the senses (hearing, seeing, touching, tasting and smelling) not based on external reality.
Hallucinosis	Ongoing hallucinations following cessation or reduction of a substance, most often alcohol, usually in a clear or mildly clouded consciousness.
Ideas of Reference	Overvalued ideas in which the patient believes people or events in his immediate environment have personal significance for him.
Looseness of associations	Speech patterns characterized by leaps from subject to subject without the connections being clear or the patient being aware of the rapid shifting.
Malingering	The voluntary production and presentation of false or grossly exagger ated physical or psychological symptoms for the purpose of secondary gain, such as avoiding difficult situations or responsibilities, receiving compensation, narcotics or protection from police, or retaliation for personal loss.
Mental Status Exam	A sum total of the examiner's observations and impressions of the psychiatric patient at the time of the interview. Includes description of the patient's appearance, speech, actions, and thoughts during the interview. (See appendix A)
Mood Disorders	Consists of two primary abnormalities of mood: depressed (persistently lowered mood) and manic (persistently elevated mood with at least three related symptoms such as increased psychomotor agitation, flight of ideas, decreased sleep, grandiosity lasting at least one week).

Major Depression — A profound lowering of mood that is present for at least two weeks and is accompanied by five associated features (vegetative symptoms) such as change in appetite, change in sleep pattern, helplessness, hopelessness, irritability, decreased concentration, decreased ADLs.

Bipolar — Disorder in which an individual has propensity to fluctuate between depression and mania, and demonstrates one or more manic episodes as well as an h/o depressive episodes.

Obsessions — Unwanted and uncomfortable ideas, thoughts, images, or impulses that persistently invade one's consciousness.

Paranoia — An intense fear related to situation that does not have a basis in reality.

Personality Disorders — A long-standing maladaptive personality trait which causes impaired life adjustment. In total there are nine sub-types of personality disorders, which are divided into three clusters:

Cluster A: Schizoid; Schizotypal; Paranoid
Cluster B: Histrionic; Narcissistic; Borderline; Antisocial
Cluster C: Obsessive-Compulsive; Dependent; Avoidant

Posturing — The assumption of relatively fixed bodily positions, usually in catatonia.

Pressured Speech — Pattern of speech that is rapid, virtually nonstop, often loud and em phatic, seemingly driven and hard to interrupt. Typically found with manic states, drug induced states and severe anxiety states.

Psychoactive Substance Use Disorder — Maladaptive behavior related to the procurement and ingestion of substances of abuse and the behavioral and social consequences of those patterns of behavior.

Psychomotor Agitation — Repetitive, nonproductive motor activity, usually associated with feel ings of tension such as pacing, fidgeting.

Psychomotor Retardation — Pattern of slowed movements, reactions and/or speech.

Psychosis	A mental state in which a person is unable to distinguish fantasy from reality.
Schizophrenia	A thought disorder characterized by the presence of psychotic symp toms such as hallucinations, delusional thinking, paranoia, social with drawal, and functional impairment. There are five types of schizophrenic disorders: Disorganized; Catatonic; Paranoid; Undifferentiated and; Residual.
Substance Induced Psychosis	Disturbance in thought pattern related to acute intoxication from alcohol, street drugs, prescription medication or toxic substances.
Suicidal Ideation	Thoughts related to the act of suicide.
Vegetative Signs	Physiological signs of depression, such as insomnia, anorexia, weight loss, diurnal mood variation, and constipation and diminished libido.

Pharmacology

Many patients with psychiatric illnesses or experiencing acute symptoms may be taking medication. It is important to know not only what the patient is prescribed but also if they have been compliant with the dose and schedule. Medications (and side effects) may include:

NEUROLEPTICS (ANTI-PSYCHOTICS)
(partial list)

Clozaril (clozapine)
Risperdal (risperidone)
Zyprexa (olanzapine)
Thorazine (chlorpromazine)
Stelazline (trifluoperazine)
Haldol (haloperidol)
Navane (thiothixene)
Mellaril (thioridazine)
Prolixin (fluphenazine)
Loxitane (loxapine)

Side effects of these medications are most commonly drowsiness, dizziness and increased heart rate but may also include anxiety and somnolence. EPS symptoms (extra pyramidal side effects including Parkinsonian tremors, dystonic reactions, and akathisia) are less likely with the newer neuroleptics, which include Clozaril, Risperdal, and Zyprexa.

MOOD STABILIZERS

Lithium (lithium)
Eskalith (lithium)
Lithobid (lithium)
Depakote (valproic acid)
Tegretol (carbamazepine)
Zyprexa (olanzapine)

Side effects initially may include drowsiness, weakness, fatigue and nausea and vomiting but these usually subside. Hand tremors and weight gain may continue to be present. Signs of lithium toxicity include diarrhea, nausea, vomiting, poor motor coordination, sluggishness, lethargy, decreased level of consciousness, drowsiness, slurred speech, ringing in ears, blurred vision, muscle twitching or weakness, visual/tactile hallucinations, involuntary eyeball movement, confusion. Symptoms of Depakote or Tegretol toxicity are often nausea and vomiting, confusion, decreased level of consciousness, tremors, and diarrhea . Patients taking lithium, Depakote, or Tegretol require routine blood level monitoring to ensure that therapeutic levels are maintained.

ANTIDEPRESSANTS

SSRIs	Tricyclics (TCAs)	MAOIs
Prozac (fluoxetine)	Elavil (amitriptyline)	Marplan (isocarboxazid)
Effexor (venlafaxine HCL)	Tofranil (imipramine)	Nardil (phenelzine)
Zoloft (sertraline)	Pamelor (nortryptilene)	Eldepry (selegiline)
Wellbutrin (bupropion)	Norpramine (desipramine)	Parnate (tranylcyprom-
ine)		
Serazone (nefazodone)	Anafranil (clomipramine)	
Paxil (paroxetine)	Sinequan (doxepin)	
Celexa (citalopam)		

Side effects of selective serotonin reuptake inhibitors (SSRIs) are generally milder than with tricyclic antidepressants (TCAs) or monoamine oxidase inhibitors (MAOIs). In general side effects can include agitation, dizziness, restlessness, difficulty sleeping, headache, and nausea. For most people, these side effects are mild and transient. MAOIs have the potentially fatal side effect of malignant hypertension (which may result in stroke) if patients do not follow a specific diet, which prohibits consumption of foods containing the chemical tyramine (i.e. cheese, liver, smoked meats, pickled foods, red wine, chocolate, coffee, raisins, pineapple and bananas). MAOI reactive signs include: throbbing occipital headache, stiff neck, chills, nausea, fever, retro-orbital pain, pallor, chest pain, and palpitations.

ANTI-ANXIETY

Valium (diazepam)
Clonopin (clonazepam)
Librium (cholordizaepoxide)
Ativan (lorazepam)
Xanax (alprazolam)
Restoril (temazepam)
Halcion (triazolam)

Side effects potentially include sedation, hypotension, light headedness, dizziness, decreased appetite, nausea, and upset stomach. As CNS depressants, mixing benzodiazepines with alcohol may result in significant depression and enhances the effect of the medication.

Synopsis

A psychiatric emergency is a situation that includes an acute disturbance in thought, behavior, mood, or social relationship, which requires immediate intervention as defined by the patient, family or social unit. These presentations include such symptoms as anxiety, depression, aggression, personality changes, delusions, and hallucinations, all of which can be aggravated by medical disorders. Studies indicate that 24-50% of patients with the aforementioned symptoms have an unrecognized coexistent medical condition. As such the first task is to address the patient safety from a medical perspective (ABCs) and behavioral perspective. The following discussion of triage and assessment is broken down by type of emergency.

Clinical Presentations

Psychiatric & Behavioral

Perhaps the most significant differential factor in the evaluation of patients with psychiatric presentations is whether the illness is organic in nature vs. functional. Organic psychiatric conditions are characterized by abnormalities of brain structure, neurochemistry or neurophysiology (see appendix B). Organic Psychiatric Disorders are diagnoses such as Delirium and Dementia. Functional Psychiatric Disorders are comprised of mood and thought disorders, anxiety disorders and personality disorders. The differentiation can be difficult when the patient presents with purely psychiatric complaints; however, identification and recognition of potentially life threatening conditions is key. Studies have indicated that four specific items are highly effective in identifying medical disease as a cause of behavioral complaints: patient age greater than 40 years with no prior psychiatric history, abnormal vital signs, recent memory loss, and clouded consciousness.

Often however, there will be multiple symptoms presenting simultaneously and it is possible that patients with a history of a functional disorder may present with a symptom that is organic in nature. In addition, many patients present with or have a history of a dual diagnosis such as an overlay between a mood disorder and substance abuse. Given the complexity of understanding and differentiating between the aforementioned diagnoses (presentations), it is not the responsibility of the EMT to delineate the most accurate diagnosis, yet an understanding of the basic presentations may assist the EMT in gathering information and providing competent field care.

1. Psychotic Disorders: Patients who present with psychosis may be suffering from anything from delirium to substance induced psychosis to schizophrenia. The symptoms that evidence themselves are varied but, in general, the patient demonstrates a state of dysfunction in which mental capacity is grossly distorted and thought is disorganized, resulting in an inability to recognize reality or relate to others in a meaningful way. Approximately 20% of psychotic patients have a medical etiology to the illness. Patients with psychoses often display *paranoia*, *delusional thinking, hallucinations*, concrete thinking, distorted perceptions and loosening of associations. Patients with psychotic features are rarely violent, however the care provider should be prepared to restrain the patient to ensure patient and worker safety.

2. Mood Disorders: These are a group of clinical conditions characterized by a loss of sense of control of mood and a subjective experience of great distress. Depression and mania are the most serious of the mood disorders. Patients with *elevated mood (mania)* demonstrate expansiveness, flight of ideas, decreased sleep, heightened self-esteem and grandiosity. Patients with *depressed* mood have a loss of energy and interest, difficulty in concentrating, loss of appetite, and *often thoughts of death or suicide*. In addition they may evidence changes in level of activity, cognitive ability and vegetative functions. Patients who demonstrate only depressive episodes are said to have *major depressive disorder* whereas patients with both manic and depressive episodes are said to have bipolar disorder. Approximately two thirds of depressed patients contemplate suicide and 10 to 15% commit suicide. Patients with mood disorders can present, in the extreme, with psychosis in which case they have a psychotic depression. Patients complaining of depression or mania present heightened challenges in the area of both patient and worker safety. EMT/FRs should be prepared to use restraints if de-escalation techniques prove ineffective.

3. Suicidal Ideation: Patients with suicidal ideation present with varying degrees of risk. Some patients have an active plan or have attempted to initiate a plan while others are said to have 'passive ideation' (a thought or wish to die without active intent). *The EMT/FR should err on the side of caution when working with patients who have articulated any suicidal ideation and/or have significant risk factors* (see appendix C). If a patient refuses treatment but the EMT/FR has concerns about the patient's safety, the EMT/FR should call for police assistance. Police have the right to detain an individual until a county designated mental health professional can evaluate the patient for detention in a mental health facility. Ultimately EMT/FRs do not have the right to detain patients or hold them against their will but they should do their best to persuade a patient at risk of self harm or harm to others to seek treatment or to stay on scene until police arrive. ***At no time however, should an EMT/FR put themselves at risk for harm and they should be aware of the increased potential from violence when working with this population.***

4. Anxiety Disorders: Patients with anxiety disorders often do not recognize their complaint as being psychiatric related. Frequently they may complain of any number of physical and psychological signs (see Appendix D). Patients with panic disorder usually describe a symptom complex consisting of shortness of breath, dizziness, and palpitations. Those with a generalized anxiety disorder have *on-going worry* and have complaints associated with motor tension, autonomic hyperactivity and vigilance. Patient with posttraumatic stress disorder often demonstrate a generalized numbing of responsiveness (i.e. restricted range of affect) and persistent symptoms of arousal (i.e. hyper-vigilance). Anxiety disorder patients often feel *helpless, frightened and out of control.* The EMT/FR should reassure patients while remaining calm and encouraging patient to express concerns.

5. Substance Abuse Disorders: With the incidence of substance abuse in all forms on the rise, and the co-existence of psychosocial issues with these disorders, emergency treatment providers are increasingly confronted with psychiatric emergencies that have substance abuse as a variable. Often patients that declare suicidal intent or are violent have a history of substance abuse and are likely toxic at the time of the complaint. Similarly, it is sometimes the abstinence from substance use (withdrawal state) that pushes a patient to claim suicidal ideation or to demonstrate behavior that is potentially harmful to himself or others.

Over time a person's CNS adapts to chronic use of chemical substances. The phenomenon of needing more of a substance to produce the effects previously attained with smaller amounts is called tolerance and is based on the amount and frequency of drug use. *Symptoms of withdrawal* occur because of the onset of physical or psychological dependence. While *tolerance* and *dependence* are physiologic terms, *drug addiction* is a social term, which refers to a person's drug-seeking behavior that is regarded as harmful to himself or others. Despite the tendency to treat these patients as purely psychiatric the EMT/FR must give consideration to the medical components of intoxication and withdrawal.

Cases of alcohol and drug abuse, presenting as acute intoxications and states of withdrawal, are the most common psychiatric conditions that are organic in nature. From a behavioral standpoint the EMT/FR should be aware of the potential for violence and/or combativeness. In addition, patients that are under the influence are not able to make rational decisions about their treatment. Thus, the EMT/FR should be prepared to confront resistance to treatment. *In most cases* (i.e. a patient that is intoxicated, claiming suicidal ideation but refusing transport) it will be necessary for the EMT/FR to call for police assistance. It may also be necessary to restrain a patient in order to administer necessary treatment.

6. Violence: Patients may be violent for many different reasons. Violence and threats of violence are frequently encountered when working with psychiatric emergencies (see Appendix E). Working successfully with these patients while preserving both patient and worker safety is challenging. An attempt to control a violently agitated patient should begin with a verbal attempt to de-escalate the situation. The treatment professional should convey an attitude of calm and control, setting limits while being prepared to deal with escalation. *EMT/FRs should assume that violence is always a possibility and protect themselves.* Do not hesitate to call for police assistance. EMT/FRs do not have a legal right to restrain the patient and enforce treatment but police officers do. However, often a patient responds favorably to being restrained and in fact, welcomes the boundaries and safety that restraints provide. If the occasion arises when an EMT/FR is called upon to restrain a patient, it should not be done without knowledge of the restraints and use protocol.

When putting a patient in restraints it is necessary to not only document the reason for restraints but also what de-escalation tactics were used, albeit unsuccessfully, in the attempt to avoid restraints.

Student Notes	***Instructor Ideas***

Subjective

History

A SYSTEMATIC APPROACH TO PATIENT CARE

In working with psychiatric patients it is important for treatment professionals to recognize that patients in physical and emotional distress are fragile and that various expectations and fantasies, often unrealistic, influence their responses to treatment. Because psychiatric complaints are often without objective criteria, subjective assessment is of particular importance. Understanding the problem from the patient's point of view is highly informative when working with psychiatric emergencies. The complaint should be recorded even if the patient provides information that appears bizarre or irrelevant. **Note: Scene Safety First**

The standard **SAMPLE** format of questioning should follow:

Symptoms

> **O**nset, what and when did it start?
> **P**rovoke, what caused it?
> **Q**uality, describe the type of feeling?
> **R**adiate or change?
> **S**everity, rate the symptoms from one to ten?
> **T**ime, how long do the symptoms last?

Allergies
Medications
Past History
Last Oral Intake
Events Leading Up To Incident

Student Notes	***Instructor Ideas***

Subjective continued

Symptoms of Psychiatric & Behavioral problems:

Onset, what and when did it start?
Provoke, what caused it?
Quality, describe the type of feeling?
Radiate, ?
Severity, rate the attack from one to ten?
Time, how long does the feelings last? chief complaint (What is the presenting problem. If patient is unable to answer, ask bystanders, family or friends.

- Ask if patient is suicidal or homicidal. Have they attempted to hurt themselves or others today or in the past?
- Is patient under the influence of alcohol or drugs?
- Suicidal or homicidal?
- Have tried to hurt themselves or others today?
- When did they start feeling this way? When did family or friends notice a change in behavior/thoughts etc.?
- Does patient have medical issues (will help determine organic vs. functional disorder) and are they taking medication.
- Psychiatric History - is patient being treated for mental health illness? Are they taking psychiatric medications (if so, as prescribed)?
- Does patient have an outpatient mental health treatment provider?

Student Notes	***Instructor Ideas***

Objective	Physical Exam

The physical exam is systematic and focused on the patient's chief complaint. When time permits, perform a more detailed exam that includes both the patient's front and back. Measure and document ***baseline vital signs*** and follow up with a second set at the end of the detailed physical exam. Unlike the subjective element of patient care, the objective element focuses on what *you* discovered during the exam. Usually, the physical exam finding fits with the patient's chief complaint.

Signs of psychiatric & behavioral include:

- Vital signs, repeat q 30 minutes
- Skin assessment (temperature, diaphoretic)
- Pupils
- Panic, Agitation, Bizarre behavior, Depression, Suicidal gestures
- Danger to self or others
- Mental Status Exam (see Appendix B)

Student Notes	***Instructor Ideas***

Assessment

Impression

Emergency Medical Technicians (EMT/FRs) are trained to deliver Basic Life Support (BLS). The information gathered by the EMT/FR regarding the patient's chief complaint (subjective) and physical exam (objective), allows the BLS Team to make an assessment or impression that leads to a treatment plan.
Before requesting a Medic response, consider whether Advanced Life Support (ALS) intervention will improve the patient's condition/outcome. Do you and your partner think that the Medic's judgment or procedures (Intubation, IV's, or Drugs) will help the patient?

It is not the responsibility of the EMT/FR to issue a psychiatric diagnosis. The impression is often a restatement of the patient's chief complaint. The most significant variables to consider are the potential for self-harm or harm to others, and whether or not the patient has indicators of an organic versus a "functional" psychiatric disorder.

ALS Indicators (Sick)

- Decreased/altered LOC
- Patient needs chemical restraint
- Abnormal behavior with unstable vitals
- Patient needs chemical restraint
- Abnormal behavior with serious co-morbidity (e.g. drug and alcohol OD)

BLS Indicators (Not Sick)

- Abnormal behavior with stable vital signs

Student Notes | ***Instructor Ideas***

Plan	Treatment

Plan continued

Management:

- **Request Medics (ALS Indicators)**
- Provide support, reassurance to patient
- Administer appropriate oxygen therapy (usually patients c/o anxiety related SOB)
- Wound care if indicated
- Call Police if necessary (if patient refuses transport but EMTs/FRs feel patient needs further evaluation)
- Use restraints when warranted (patient is a danger to self or others)
- Monitor patient behavior and physiological changes, do not leave patient alone or turn your back

Detail Skills:

- Do not leave patient alone or turn your back
- Speak in a calm quiet voice, maintain eye contact and move slowly
- Answer questions honestly
- Restrain only if necessary for your protection or that of the patient
- Prepare patient for transport (backboard, scoop stretcher)
- Deliver short radio report to on route medic unit (if necessary)
- Transport to appropriate medical facility
- Monitor vital sign every five to ten minute

See Appendix at the end of this module for treatment & destination decisions

APPENDIX A

MENTAL STATUS EXAM OUTLINE

1. General Description
   - Appearance
   - Behavior and psychomotor activity
   - Attitude toward examiner

2. Mood and affect
   - Mood
   - Affect
   - Appropriateness

3. Speech

4. Perceptual disturbances

5. Thought
   - Process or form of thought
   - Content of thought

6. Sensorium and cognition
   - Alertness and level of consciousness
   - Orientation
   - Memory
   - Concentration
   - Abstract thinking
   - Fund of information and intelligence

7. Impulse control

8. Judgment and insight

9. Reliability

APPENDIX B

FEATURES INDICATING ORGANIC CAUSE
OF MENTAL DISORDER

1. Acute onset (within hours or minutes, with prevailing symptoms)
2. First episode
3. Geriatric age
4. Current medical illness or injury
5. Significant substance abuse
6. Non-auditory disturbances of perception
7. Neurological symptoms - loss of consciousness, seizures, head injury change in headache pattern, change in vision.
8. Classic acute mental status signs - diminished alertness, disorientation, memory impairment, impairment in concentration and attention, concreteness
9. Other mental status signs - speech, movement, or gait disorders
10. Catatonic features - nudity, negativism, combativeness, rigidity, posturing, waxy flexibility, echopraxia, echolalia, grimacing, muteness.

APPENDIX C

FACTORS ASSOCIATED WITH SUICIDE RISK

1. Age (45 and older)
2. Alcoholism
3. Irritation, rage, violence
4. Prior suicidal behavior
5. Sex (male)
6. Unwilling to accept help
7. Longer duration of current episode of depression
8. Prior inpatient psychiatric treatment
9. Recent loss or separation
10. Depression
11. Loss of physical health
12. Unemployed or retired
13. Single, widowed, divorced

HISTORY, SIGNS AND SYMPTOMS OF SUICIDAL RISK

1. Previous attempt or fantasized suicide
2. Anxiety, depression, exhaustion
3. Availability of means of suicide
4. Concern for effect of suicide on family members
5. Verbalized suicidal ideation
6. Preparation of a will, resignation after agitated depression
7. Proximal life crisis, such as mourning or impending surgery
8. Family history of suicide

APPENDIX D

SIGNS AND SYMPTOMS OF ANXIETY

PHYSICAL SIGNS	PSYCHOLOGICAL SYMPTOMS
Trembling, twitching, feeling shaky	Feeling of dread
Backache, Headache	Difficulty concentrating
Muscle tension	Hypervigilance
Shortness of Breath, Hyperventilation	Insomnia
Startle response	Decreased libido
Autonomic Hyperactivity	Lump in the throat
Flushing and pallor	Butterflies in stomach
• Tachycardia, palpitations	
• Sweating, Cold hands	
• Diarrhea	
• Xerostomia (dry mouth)	
• Urinary frequency	
• Parasthesia (Difficulty swallowing)	

MEDICAL DISORDERS ASSOCIATED WITH ANXIETY

Cardiovascular System	Respiratory System	Gastrointestinal System
Cardiac arrhythmias	Asthma	Colitis
Cardiomyopathies	COPD	Crohn's disease
Congestive Heart Failure	Hyperventilation	Irritable bowel syndrome
Coronary insufficiency	Pneumothorax	Peptic ulcer disease
Mitral Valve Prolapse	Pulmonary edema	
Myocardial Infarction	Pulmonary embolism	

Neurological System	Endocrine System
AIDS	Adrenal insufficiency
Dementia and Delirium	Carcinoid syndrome
Epilepsy	Cushing's syndrome
Essential tremor	Hyperparathyroidism
Huntington's chorea	Hyperthyroidism
Lupus cerebritis	Hypoglycemia
Multiple sclerosis	Hypokalemia
Parkinson's' disease	Hypothyroidism
Vestibular dysfunction	
Wilson's disease	

APPENDIX E

TRANSPORTATION DECISIONS

1. Leave at scene

BLS Indicators with little or no potential for patient to worsen
EMT feels confident that patient is responsible for self-care, or that another responsible party is present
EMT urges patient to call back if further concerns or problems arise
EMT reminds patient to follow up with private MD if appropriate

Patient refusal signed ONLY if (a) EMT believes patient SHOULD go to medical facility and (b) patient refuses treatment/transportation

Patient who is recovering from a typical seizure, is neurologically intact with stable vital signs.

2. Patient's Own Vehicle (POV)

BLS Indicators with little or no potential for patient to worsen with further evaluation or treatment neededResponsible transportation is available

Patient who is recovering from a typical seizure, is neurologically intact with stable vital signs.

3. BLS Aid Car/Private Ambulance

BLS Indicators

Further evaluation or treatment needed

Continued BLS assessment, oxygen or other treatment needed en route

No other responsible transport available

Patient requires stretcher for transport

4. ALS

ALS Indicators

Continued ALS assessment or treatment needed during transport

Destinations for further care – Options available include:

1. Self-care

BLS Indicators with little or no potential for patient to worsen
EMT feels confident that patient is responsible for self-care, or that another responsible party is present
EMT urges patient to call back if further concerns or problems arise
EMT reminds patient to follow up with private MD if appropriate
Patient refusal signed ONLY if a) EMT believes patient SHOULD go to medical facility and b) patient refuses treatment/transportation
Typical seizure, neurologically intact, patient wants to stay home
Syncope in a young person, normal vital signs, no complaints

2. Clinic or Doctor's office

BLS Indicators with little or no immediate portntial for patient's condition to worsen
Need for further evaluation and treatment
Facility is available and capable of assessing and treating the patient
Facility agrees to see patient
Patient has transportation to and from the facility considered
Typical seizure, neurologically intact, physician requests visit

3. Hospital Emergency Room

ALS or BLS indicators with need for further medical evaluation and treatment
No other facility appropriate or available to see patient
First or atypical seizure
All overdoses
Syncope of unknown or cardiac etiology